NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death of Amir Hall, an inmate of the Great Meadow CF	FINAL REPORT OF THE NEW YORK STATE COMMISSION OF CORRECTION

TO: Honorable Brian Fischer
Commissioner
NYS Department of Correctional Services
State Campus, Building #2
Albany, New York 12226

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Amir Hall who died on June 20, 2010 while an inmate in the custody of the NYS Department of Correctional Services at the Great Meadow Correctional Facility, the Commission has determined that the following final report be issued.

FINDINGS:

1. Amir Hall was a 23 year old black male who died from suicidal hanging on 6/20/10 at 3:37 p.m. Hall was housed in the Special Housing Unit at the Great Meadow Correctional Facility while in the custody of the NYS Department of Correctional Services (DOCS).

2. [redacted]

3. [redacted]

[redacted]

7. [redacted]

8. [redacted]

9. [redacted]

[redacted]

4. [redacted]

5. [redacted]

6. [redacted]

[redacted]

10. [redacted]

11. [redacted]

12. [redacted]

[redacted]

13. [redacted]

14. [redacted] This is a notable lapse in the continuity of care for an incoming draft.

15. [redacted]

16. [redacted]

17. [redacted]

18. Hall met with his correction counselor for the first time on 12/8/09, nearly five weeks after his arrival at Downstate CF. This is in violation of DOCS Directive #4401, *Guidance and Counseling Services*, which states that "Each inmate is interviewed and assessed by the assigned counselor within five working days of arrival at a new facility." This Directive is designed to ensure that case management, purposeful counseling, and monitoring are performed in a consistent and systemic manner.

Documentation by Hall's counselor emphasized his need to participate in sex offender counseling, his need to

participate in ART program, suicide prevention counseling, and "need for psych meds on permanent basis."

19. On 12/10/09, Hall was transferred to Mid-State CF. [redacted]

20. [redacted]

21. [redacted]

22. [redacted] In interview, the psychiatrist stated that the [redacted] was more effective for sleep and was not particularly beneficial for depression. [redacted] The Board found that the patient's [redacted] should not have been discontinued without explanation and alternative anti-depressive therapy consideration.

23. [redacted]

[redacted] Hall received a Tier 2 ticket for Loss/Damage Property.

24. [redacted]

25. [redacted]

26. [redacted]

27. On 1/29/10, Hall received a Tier 2 disciplinary ticket for Property Unauthorized Location, Smuggling and Unreported ID

Change. On 2/2/10, Hall received a Tier 2 disciplinary ticket for Direct Order.

28. [redacted]

29. [redacted]

30. On 2/17/10, Hall was placed in SHU for 21 days keeplock following a disciplinary hearing for his recent disciplinary tickets. [redacted] It should be noted that SHU inmates are seen daily by mental health on SHU rounds and are offered private out of cell encounters bi-weekly.

31. [redacted]

32. [redacted]

33. On 3/12/10, Hall was involved in an altercation with another inmate and received a Tier 2 disciplinary ticket for Creating a Disturbance and Fighting. He was transferred to SHU [redacted]

34. [redacted]

35. [redacted]

36. [redacted]

37. On 4/20/10, Hall was involved in an altercation with another inmate receiving a Tier 2 disciplinary ticket for Violent Conduct and Creating a Disturbance. He was transferred to SHU [redacted]

38. [redacted]

[redacted]

39. [redacted]

40. [redacted]

41. [redacted]

42. [redacted]

43. On 5/8/10, Hall threw an unknown liquid on an officer making a round past Hall's cell in SHU. The liquid was sent out for testing and Hall was charged with Assault on Staff and Unhygienic Act.

44. [redacted]

45. [redacted] Being as the thyroid gland regulates metabolism and can be associated with weight gain and loss, vital signs and weight should be measured during clinical encounters. [redacted]

46. [redacted]

47. On 6/2/10, Hall received yet another disciplinary ticket for Violent Conduct, Assault on Staff and Unhygienic Act after throwing liquid on another officer serving chow. The liquid was determined to be Kool Aid but a hearing would be conducted likely resulting in disciplinary sanctions.

48. [redacted]

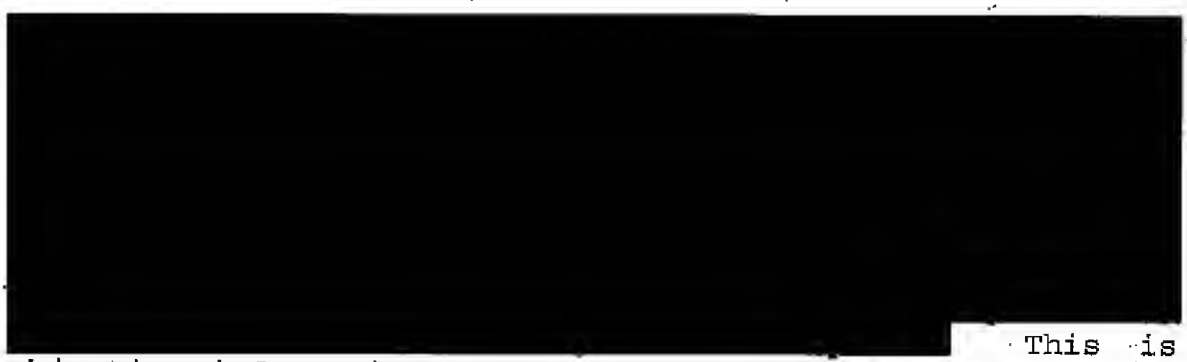
49. [redacted]

50. [redacted]

51. A disciplinary hearing was held on 6/9/10 and Hall received seven months SHU time for Staff Assault. He was to be an SHU to SHU transfer to Great Meadow CF (GMCF).

52. [redacted]

53. [redacted]



This is objective information that should only be completed with a clinical encounter. In consult with the State Education Department's Office of Professional Discipline, this entry constitutes unprofessional conduct according to Rules of the Board of Regents, Part 29.2(a)(3) which states in part, "failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient."

This is also a violation of CNYPC Corrections-Based Operations Policy and Procedure #7.2 *Active Transfers*, which states in part, *"The primary therapist completes the Termination/Transfer Progress Note."*

54. On 6/18/10 at approximately 8:20 a.m., Hall was directed to accept draft and prepare to leave. According to the supervisory log, he refused to speak but nodded his head in agreement. At approximately 8:37 a.m., Hall refused to leave his cell for the draft. The Watch Commander was notified. Hall refused several direct orders to leave his cell. He was then interviewed by the executive team, ministerial services, mental health services, and the Crisis Intervention Unit (CIU), all attempting to coax him to comply.

55. R.D., SWII, stated in interview that he received a call from the sergeant asking him to respond to SHU to talk with Hall. He stated that he checked the computer for any useful information. He responded to Hall's cell where he spent approximately 10-15 minutes attempting to communicate with Hall. He mentioned Hall's mother and siblings and spoke of the fact that Hall would be moving closer to home. R.D. reported that Hall remained on his bunk with a sheet over his head during the entire encounter. This encounter was not recorded in the mental health record and is not required according to the Unit Chief. R.D. finished SHU rounds and left the unit. He had no further contact with Hall and did not relay this information to the GMCF OMH.

56. Hall continued to refuse to comply. The superintendent then authorized a cell extraction and the use of chemical agents. Hall was given a final order to comply but remained lying on

his bunk, ignoring the order. The first application of CS was administered through the feed-up hatch. After sufficient had elapsed and without effect a second application was administered. Again after sufficient time had elapsed and still no effect, a third application was administered. All applications were 2 one second bursts in compliance with the use of chemical agents. At this time, Hall agreed to comply with all orders and backed up to the feed=up door to be handcuffed. A retention strap was used to ensure compliance. Hall was then escorted to the 10-1 shower area for decontamination. A strip frisk was performed without incident. [redacted]

57. Hall was dressed and prepared for transport to GMCF. Video tape was running throughout the entire SHU incident and up until Hall was placed in the transport van for transfer to GMCF. His transport was described by the transport officers as routine. They did not recall any conversation or unusual behavior from Hall.

58. Great Meadow CF was not notified of Mid-State SHU incident prior to Hall's arrival at the facility. Although it was a common practice in DOCS for a sending facility to brief a receiving facility of any problems concerning the inmate prior to transfer, no policy existed. On 9/24/10, the Department issued a Memorandum to all Superintendents regarding Inmate Transfers/Information Sharing which essentially states that the sending facility Deputy Superintendent for Security or designee shall advise their counterpart at the receiving facility that an inmate who is the subject of critical concern is being transferred.

59. Hall arrived at GMCF at approximately 2:20 p.m. and was processed in as an SHU to SHU transfer. During this process, cuffs and chains are exchanged with the sending facility. Hall was then instructed to strip down to his shorts and then received his jumpsuit and SHU shoes. He was described as "nervous," "not saying a lot," "not listening."

60. Prior to Hall's SHU admission, a health screening would be completed by a registered nurse. DOCS Division of Health Services Policy #1.44, Health Screening of Inmates, states: *"Upon arrival at a DOCS facility, every newly received or transferred inmate will receive a health screening by an RN that includes an inquiry into the inmate's current and past health/mental health history and immediate referral of any inmate to a health provider if indicated."*

[redacted]

Z.K., RN, was terminated from service following her acknowledging this failure to following policy and procedure. She was referred by DOCS Health Services to the State Education Department, Office of Professional Discipline.

61. Per Dr. D.D., GMCF Unit Chief, no referrals were received by mental health. Hall would not have been seen by mental health until 6/21/10 during mental health's SHU rounds unless notified otherwise.

62. Hall was admitted to SHU at approximately 2:40 p.m. At approximately 2:36 p.m., Sgt. J.K. conducted the *Suicide Prevention Screening Guidelines - SHU admission* according to DOCS Directive #4101, Suicide Prevention. Hall denied feeling suicidal but when questioned, "Do you feel like you have nothing to look forward to in the future?", he initially answered "yes." Sgt. J.K. stated that he asked him again if he really believed that there was nothing to life for. Hall then answered that there was something to live for and that he hadn't understood the question. Hall stated that he had been seen by mental health during his incarceration but was not currently an active mental health patient. Due to his history, a routine referral was made to mental health. In interview, Sgt. J.K. stated that Hall appeared somewhat nervous during the screening process.

63. At approximately 2:48 p.m., N.S., RN, conducted the *Ambulatory Health Record Special Housing Admission* per DOCS Directive #4933, Special Housing Units. [redacted] In interview, she reported that he was a routine SHU admission and did not appear depressed.

64. On interview, SHU officers described Hall as quiet after his arrival to GMCF SHU mostly lying on his bed all day. No one recalled any conversation with Hall or anything unusual. Hall had refused a shower and his meals on 6/19/10 but had accepted breakfast on 6/20/10 and refused lunch.

65. On 6/20/10 at approximately 1:35 p.m., Officer L.M. was making a hot water delivery on the even side of SHU F block when he

observed Hall hanging from a torn bed sheet which was secured to the upper left hand side of the cell gate in his cell. Officer L.M. notified the console officer, Officer R., and responded back to the cell with Officers R.S. and L.C. Officer R. Notified the cell hall via his personal alarm system (PAS) of the medical emergency prompting an emergency response to the unit including medical staff and area supervisor, Sgt. S.K. The officers had difficulty opening the cell door due to Hall's location and the placement of the ligature. Officer L.M. reached into the cell through the feed-up port attempting to lift hall and release pressure on the ligature as Officer L.S. cut the ligature from Hall's neck. The officers entered the cell and discovered hall unresponsive and without any signs of breathing. The AED was applied and reported no shock advised. Officer L.M. began chest compressions and Officer N.Y. applied the bag valve mask (BVM).

[redacted] There was no suicide note found. Hall was last seen alive at 1:10 p.m.

66. [redacted] These all constitute significant changes in Hall's mental status. In addition, he continued with poor disciplinary behavior, engaged in recent violent behavior, was isolated in a single cell, and had little family contact. Despite these changes, there was no revision to his treatment plan and/or recommendation for evaluation for psychotropic medication intervention.

67. [redacted] Hypothyroidism is often associated with depression and anxiety. Due to Hall's non-compliance with medications, it would seem prudent that it would be factored into his treatment plan.

68. [redacted]

[redacted] These issues were not addressed during clinical encounters nor were they identified as risk factors and were not included in his treatment plan. It should be noted that Hall did not sign his treatment plan as required per OMH policy.

69. Although Hall was referred by Downstate CF to the SOP Program, he was never enrolled in the program. He was not considered available for programming due to his frequent disciplinary actions resulting in keeplock and SHU status.

70. In reviewing the record in this case, the Medical Review Board found that Amir Hall suffered from Borderline Personality Disorder and post-Traumatic Stress Disorder, mental disorders for which there are very limited programming and treatment options available in the prison system. The condition of a patient with these disorders can be expected to worsen while incarcerated. In the case of Amir Hall, as his mood and behavior became increasingly unstable, punitive responses to those behaviors led to further decompensation, while treatment interventions decreased.

RECOMMENDATIONS:

TO THE NYS DEPARTMENT OF CORRECTIONAL SERVICES AND TO THE NYS DEPARTMENT OF CORRECTIONAL SERVICES, DIVISION OF HEALTH SERVICES:

The Department shall review Hall's admission and incarceration at Downstate Correctional Facility, specifically, the failure of Health Services to recognize and continue Hall's medication, and Hall's untimely Guidance and Counseling Assessment.

TO THE NYS DEPARTMENT OF CORRECTIONAL SERVICES, DIVISION OF HEALTH SERVICES:

1. The Division shall comply with Policy 1.44, Health Screening of Inmates, which states: "Upon arrival at a DOCS facility, every newly received or transferred inmate will receive a health screening by an RN that includes an inquiry into the inmate's current and past health/mental health history and immediate referral of any inmate to a health provider if indicated."

2. The Division's Quality Improvement Committee should review compliance with Policy 1.44, Health Screening of Inmates, at all DOCS facilities, specifically: are they being completed on

all admissions and are they being completed during a clinical encounter versus completion by chart review.

3. The Division should conduct a review of Hall's medical care, [redacted] during his incarceration at Mid-State CF. The review should focus on the failure to measure his vital signs and weight, his refusal of medication and communication of this information to his mental health clinician.

TO THE NYS OFFICE OF MENTAL HEALTH, DIVISION OF FORENSIC SERVICES:

1. The Division shall comply with CNYPC Corrections-Based Operations Policy and procedure #7.2 Active Transfers. The policy should be reviewed and revised to comply with the State Education Department's Rules of the Board of Regents.

2. The Division shall review Hall's clinical care prior to transfer to Great Meadow CF, specifically, his mental status changes with no revisions to his treatment plan. Also, a review of risk factors not included in his treatment plan.

3. The Division shall develop a policy and procedure for formal notification of a receiving facility of a problematic transfer, i.e., Chemical Agents Use, Cell Extraction, and Use of Force prior to transfer. In addition, encounters such as the incident at Mid-State CF whereby mental health interventions are requested shall be documented as required of all clinical encounters.

4. The Division shall conduct an inquiry into why a TRICP Program was not explored as recommended according to CNYPC Discharge Plan.

5. DOCS inmates suffering from both Borderline Personality Disorder and Post-Traumatic Stress Disorder are an extremely difficult population of prisoners who require the use of little-known but effective tools for early identification and effective preventive intervention. The Division should consider special treatment of this population with early accurate diagnosis, followed by treatment in an appropriate setting with psychotropic medication. Dialectical Behavior Therapy, as well as antidepressants and second generation antipsychotics, is indicated.

TO THE NYS DEPARTMENT OF CORRECTIONAL SERVICES, DIVISION OF HEALTH SERVICES AND THE NYS OFFICE OF MENTAL HEALTH, DIVISION OF FORENSIC SERVICES:

The Divisions should develop a formal process of communication between medical and mental health providers to share appropriate information that may have clinical implications in their treatment plans.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 24th day of June, 2011.

Phyllis Harrison-Ross, M.D.
Commissioner

PH-R:mj
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cc: Superintendent Norman Bezio, Great Meadow CF
Dr. Carl Koenigsmann, Chief Medical Officer
Elizabeth Ritter, Assistant Commissioner
Richard Miraglia, Division of Forensic Services, NYS Office of Mental Health
Don Sawyer, Executive Director, Central New York Psychiatric Center
Jayne VanBramer, Director, Bureau of Quality Management, OMH